SE Geriatric Logo.tif

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**Facility Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I hereby authorize the following:**

1. I fully understand that **insurance does not cover everything** **and I may be held financially responsible for services rendered by a Nurse Practitioner.**
2. I authorize examination and treatment for this and the entire following physician or Nurse Practitioner visits performed by SGHG.
3. I authorize SGHG to obtain records from other sources as may be necessary for the diagnosis and treatment.
4. I authorize to release any medical information necessary to process insurance billings.
5. I authorize payments of insurance benefits otherwise due to me to be made directly to SGHG.
6. I authorize assignment of insurance benefits to SGHG.
7. I have read and reviewed SGHG’s Notice of Privacy Practices (HIPAA).
8. I shall be personally responsible for **supplying** **accurate and current insurance information.**
9. I fully understand that I am financially responsible **for** **all charges and deductibles not covered by insurance.**
10. I fully understand that **Blue Cross/Blue Shield does not contract with Nurse Practitioners** and I may be held responsible for charges if I have BCBS policy.

**Invoices and correspondence should be sent to:**

 **Check here if you would like to receive invoices by email Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Billable/Responsible Party Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party/Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**